Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GERRY NICHOLS OTR
PO BOX 121586
ARLINGTON TX 76012

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1440-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid per the Fee Guideline"

Amount in Dispute: $582.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement was provided

Response Submitted by: Specialty Risk Services, 1851 East 1st St. #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2010	97750-FC	$582.66	$404.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for Professional Services.
4. 28 Texas Administrative Code §130.6 sets out rules for testing to support a Designated Doctor service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 03, 2010

- 214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Claim denied. Please contact the SRS Claims Examiner regarding these charges.

Explanation of benefits dated December 07, 2010
- 18 – Duplicate claim/service.
- 214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Claim denied. Please contact the SRS Claims Examiner for further information.
- Note – Charges reviewed under DCN 2006829 (Gerry Nichols, OTR)

Explanation of benefits dated January 17, 2011
- Services denied. Please contact the SRS Claims Examiner regarding these charges.

Issues

1. Did the Respondent deny services using appropriate denial codes?
2. Did the requestor perform Functional Capacity Evaluation (FCE) testing in support of a Designated Doctor Examination (DDE) per 28 Texas Administrative Codes §134.204(g). and §130.6?
3. Is the requestor entitled to reimbursement?

Findings

1. The Respondent denied reimbursement based upon 18 -duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payment. Therefore, this payment denial reason has not been supported. The Respondent also used 214, indicating that the claim was not compensable. There is no PLN-11 which denies any of the services performed as lumbar/hip strain is compensable area on file. Either way, a Designated Doctor service was ordered for Return to Work status and performed October 5, 2010 and this testing is in support of that evaluation, therefore a compensability denial is not appropriate.
2. The FCE was billed for 13 units, however 9 units were documented with a Start Time of 12:30 PM and a Stop Time of 2:45 PM.
3. Review of the submitted documentation finds that requestor is entitled to additional reimbursement according to the 28 Texas Administrative Code §134.203(c) MAR methodology for 9 (15 minute increment) units at $44.90 per unit provided in 28 Texas Administrative Code §133.203 for ZIP Code 75247 in Dallas County. The total MAR recommended is $404.12.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $404.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $404.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20 ,2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.